INFORMATIONAL REPORT ON PEDIATRIC DENTISTRY PROGRAMS ANNUAL SURVEY CURRICULUM DATA

Background: At its Winter 2015 meeting, the Commission directed that each Review Committee review a draft of its discipline-specific Annual Survey Curriculum Section during the Winter meeting in the year the Survey will be distributed. The Commission further suggested that each Review Committee review aggregate data of its discipline-specific Annual Survey Curriculum Section, as an informational report, when the materials are available following data collection and analysis. The Commission noted that all survey data is considered confidential at the programmatic level.

The Curriculum Section of the Commission's Annual Survey is conducted for pediatric dentistry programs in alternate years. The most recent Curriculum Section was conducted in August/September 2024. Aggregate data of the most recent Curriculum Section for review by the Pediatric Dentistry Review Committee as an informational report is provided in **Appendix 1**.

Summary: The Review Committee on Pediatric Dentistry Education is requested to review the informational report on aggregate data of its discipline-specific Annual Survey Curriculum Section (**Appendix 1**).

Recommendation: This report is informational in nature and no action is requested.

Prepared by: Ms. Taylor Weast

2024-25 Pediatric Dentistry Curriculum Survey Results

This report includes data collected in the 2024-25 *Survey of Advanced Dental Education* from 84 advanced dental education programs in pediatric dentistry accredited at the time of the survey. Three programs did not have residents enrolled during the curriculum survey period; data from these programs are not included in this report.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?

Field	Minimum	Maximum	Mean	Count
a. Clinical (include related laboratory activity)	50.0	90.0	68.8	84
b. Didactic (include assigned laboratory activity)	5.0	35.0	17.8	84
c. Research	0.0	20.0	6.9	84
d. Teaching	0.0	20.0	4.7	84
e. Other, please specify	0.0	22.5	1.8	84

e. Other, please specify - Text

Advocacy and Offsite Rotations
Advocacy/ Outreach
Board Study, Outreach Events/Mission Trips, Advocacy
Community Outreach
Community Service/Outreach
First year rotations
Grading proctored OSCE exams
Hospital Rotations (3)
Hospital rotation, advocacy, and AAPD activities
Leadership, Enrichment and Professional Development
Outreach (2)
Outreach, Interdisciplinary Collaboration
Rotations (2)
Rotations, IPE, continuing education, etc.
Service to Community
Volunteerism, community outreach
advocacy, community outreach, rotations
advocacy, public policy, professional meetings
head start project

22. Please estimate the total number of clock hours (didactic and clinical) of instruction students/residents receive in each of the following subject areas during the entire program.

Field	Minimum	Maximum	Mean	Count
a. Biomedical Sciences (Biostatistics and Clinical Epidemiology, Pharmacology, Microbiology, Embryology, Genetics, Anatomy and Oral Pathology)	0	1,080	151.1	84
b. Behavior Guidance (Non-pharmacological techniques, Sedation, and Inhalation analgesia)	0	5,000	594.1	84
c. Growth and Development (Craniofacial growth and development/Normal and abnormal physical, psychological and social development)	0	3,616	258.2	84
d. Oral Facial Injury and Emergency Care	0	2,000	231.9	84
e. Oral Diagnosis, Oral Pathology and Oral Medicine and Radiology	0	3,500	277.8	84
f. Prevention and Health Promotion	0	4,500	480.0	84
g. Comprehensive Dental Care	0	4,500	985.6	84
h. Management of a contemporary dental practice (e.g., Ethics)	0	1,050	57.3	84
i. Patients with Special Care needs	0	5,000	454.0	84
j. Hospital dentistry	0	4,500	483.4	84
k. Pulp therapy	0	2,000	198.4	84
l. Pediatric medicine (i.e., Speech and language development)	0	500	114.1	84
m. Advocacy	0	350	41.8	84
n. Other, please specify	0	1,728	36.8	84

n. Other, please specify - Text

AAPD activities and Exams
Daily clinical training.
Global Health, Telehealth, Cultural Competency and Diversity, Safety Curriculum, Socail Determinants of Health,
Ortho
QI, internal CE, research
Research (2)
Restorative, Child Development, Dental Materials, Leadership
Total Clock hours
multi-specialty clinics

Comments from Pediatric Dentistry Curriculum Section page 1

Advocacy: Program participated in AAPD Oral Health Advocacy Conference in Washington DC. It was a three-day event - totaling about 16 hours.

It is difficult to quantify the clock hours for didactic and clinical instruction in the various categories. As a hospital-based program, instruction is provided both in the classroom and clinic setting and is very dynamic throughout residency training. The clock hours listed are a best approximation for the number of classroom hours combined with the number of clinical experiences in each area with consideration that a faculty member may be directly assisting the resident and/or answering clinical questions. Instruction hours and clinical experiences during rotations were also factored into the totals.

None found

This is a fully engaged residency training program with faculty who are actively involved in clinical and instructional interactions and continuous learning opportunities through mentorship, participation, and didactic instruction.

This was harder to calculate than I expected because many of the topics overlap, specifically with clinical instruction. I answered to the best of my ability.

many topics overlap.

23. In which of the following conscious sedation techniques did students/residents receive instruction and clinical experience during the 2023-24 academic year?

Instruction	Yes	No	Total
a. Oral	100.0%	0.0%	84
b. Inhalation	97.6%	2.4%	84
c. Intramuscular	75.0%	25.0%	84
d. Intravenous	83.3%	16.7%	84
e. Other, please specify	31.0%	69.0%	84

Clinical experience	Yes	No	Total
a. Oral	100.0%	0.0%	84
b. Inhalation	95.2%	4.8%	84
c. Intramuscular	28.6%	71.4%	84
d. Intravenous	52.4%	47.6%	84
e. Other, please specify	31.0%	69.0%	84

e. Other, please specify - Text

General Anesthesia (2)
Intranasal (19)
Intranasal & Submucosal
Nitrous oxide analgesia
Submucosal/ Intranasal (2)
Transmucosal
submucosal

24. What is the average number of experiences per student/resident using minimal and moderate sedation during the 2023-24 academic year?

a. Minimal sedation	Minimum	Maximum	Mean	Count
Less than 4 years old	0	500	17.4	84
4 years to less than 9 years old	0	772	71.8	84
9 years to less than 13 years old	0	510	40.0	84
13 years old and above	0	5,000	73.0	84

b. Moderate sedation	Minimum	Maximum	Mean	Count
Less than 4 years old	0	30	4.7	84
4 years to less than 9 years old	0	126	23.2	84
9 years to less than 13 years old	0	35	5.8	84
13 years old and above	0	30	2.5	84

25. What is the average number of general anesthetic patients managed by each student/resident during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
a. Hospital-based general anesthetics	0	150	46.1	84
b. Clinic/Office-based general anesthetics	0	99	6.5	84
c. Other, please specify	0	17	4.3	4

c. Other, please specify - Text

IV Sedation

Comments from Pediatric Dentistry Survey Curriculum Section page 2

- We consider minimal sedation the utilization of a single agent with no respiratory depressant effect such as Hydroxyzine. - IV sedations are only performed at the **REDACTED** site.

24. The IM/ IV instruction is given during the anesthesia rotation (i.e. deep sedation or general anesthesia), and not used for minimal/moderate sedation.

24. The numbers presented are based on sole operator and does not include any monitoring.

25.B. In February of 2024 we started treating patients under deep sedation with a pediatric anesthesiologist using IV propofol 1 day per month. We completed 25 cases during the spring of 2024. Moving forward we anticipate completing approximately 8 cases per month or approximately 1 patient per resident per month.

REDACTED is an off-site rotation not owned by **REDACTED**. Therefore, patients are not patients of record and no demographical data is collected. For 2023-2024, 83 total cases for code D9230 which is minimal sedation were recorded but not included in Question 24. If divided by 16 residents, that would be an additional 5 cases per resident.

For oral conscious sedation, we use morphine, versed and hydroxyzine, and often combine 2-3 agents. Each resident completed 31 cases/resident.

Implemented electronic procedure logs in '23. Likely that nitrous oxide (included in minimal sedation numbers) isn't adequately reflected. Minimal sedation includes Nitrous-, Ativan-, or Versed-only. Moderate sedation includes 2 drugs. Average 375 ORs yearly with residents as operators. These are 1 year numbers.

Included N2O cases as minimal sedation.

Minimal sedation includes patients seen at off-site locations.

Q24: Clinical experiences using moderate sedation are weighted toward residents in their second year. Q25: Clinical experiences using general anesthesia are weighted toward residents in their second year.

Question 24b moderate sedation: Cases are run with a primary operator (a PGY-2) and a secondary monitor (PGY-1). This was calculated for the primary operator ONLY. The average for all students in the program therefore doesn't capture experiences as a monitor and the average PGY-1 experiences as primary operator are close to 0.

The Department of Pediatric Dentistry has two in-house general anesthesia suites that allows the residents to provide care to healthy children and children with special healthcare needs under the age of 18 years. In addition, there are three in-house general anesthesia suites in the Center for Patients with Special Needs. Our residents spend two semesters treating adult special needs patients one-half day/week to receive additional general anesthesia training.

The clinic is not located in the hospital, so minimum to moderate sedation procedures are permitted there. Hospital-based GA cases must be admitted through the hospital's same-day ambulatory care unit.

Total number of OR cases seen was 176. Average reported does not reflect total number of cases per resident, as only half of them rotate at the OR in 1 year.

26. How many patient visits were managed by all students/residents during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	0	17,0230	13,561.1	84

27. Of all the patient visits identified in Question 26, what percentage were patients with diagnosed emotional, physical, or mental problems managed by the advanced pediatric dentistry students/residents?

Field	Minimum	Maximum	Mean	Count
	1.0	100.0	39.4	83

28. Please indicate whether each hospital service rotation is required or an elective.

Question	Required	Elective	Not applicable	Total
a. Anesthesiology	100.0%	0.0%	0.0%	84
b. Emergency Room	77.4%	3.6%	19.0%	84
c. Pediatric Medicine	98.8%	0.0%	1.2%	84

28. Please indicate the total length of each hospital service rotation in weeks.

Field	Minimum	Maximum	Mean	Count
a. Anesthesiology	4.0	12.0	4.4	84
b. Emergency Room	0.6	48.0	3.8	68
c. Pediatric Medicine	1.0	48.0	3.2	83

28. Please indicate whether the number of hours per week spent by students/residents on each rotation.

Field	Minimum	Maximum	Mean	Count
a. Anesthesiology	7.0	50.0	38.0	84
b. Emergency Room	4.0	60.0	32.4	68
c. Pediatric Medicine	7.0	80.0	37.4	83

28 (continued). Please identify other hospital rotations not listed in lines a-c above.

d. - (please specify)	e. - (please specify)	f. - (please specify)
Oral Surgery	Adult Special Health Care Needs	advacacy
Autism Clinic (2)	Ambulatory/medical sub-specialties	Cleft
Cleft Lip and Palate Clinic	Cleft Palate	Complex Care
Cleft palate/craniofacial anomalies team	Craniofacial (4)	CPTI-Community Partnership Training Initiative
Community Clinics	Craniofacial and Cleft Lip and Palate	Craniofacial (4)
Core Lecture	Developmental Medicine	Craniofacial Team
Craniofacial (5)	Domestic Abuse Team	Emergency Call
Craniofacial Anamolies Clinic	Elective- Multi Specialty	Emergency clinic service
Craniofacial Anomalies	Genetics	Externship
Craniofacial Clinic (4)	**REDACTED** rotation	Foster Care clinic
Craniofacial Team (2)	**REDACTED** Oncology Clinic	Hematology Clinic
Craniofacial rotation	Hematology Clinic	Hemophilia
Craniofacial/cleft palate	Hematology Oncology (4)	IV sedation
REDACTED office	Hemophilia Team	OMFS
ENT	Hemotology/Oncology	Oral Surgery (2)
Hematology (2)	In-patient	Orthodontics
Hematology-Oncology	multi discipline neuromuscular	Outreach
Hospital day call/consult	Multidisciplinary	Pediatric Plastic Surgery
Hospitalist	OMFS	Sickle Cell and Neuro
REDACTED Pediatric	on all	Special Needs
M&M infectious disease Pediatric Medicine Morning Reports	On-Call (home call)	Subspecialties
Medicine	Oral & Maxillofacial Surgery	**REDACTED**
NICU	Oral Surgery	
Neurobehavior	Orthodontics	
Oncology	Pediatric Dental Trauma	
Operating Room (2)	Pediatric Genetics	
Operating Room	Pediatric Infectious Disease	
Oral Maxillofacial Surgery (2)	Plastic surgery	
Oral Path	Plastics/**REDACTED**/Spina Bifida/Oncology	
Oral Surgery (5)	sedation	
Orthodontics	Special Needs	
Pediatric Otolaryngology	Special Needs Clinic	
Pediatric Physical Assessment	Survivorship	

d. - (please specify)	e. - (please specify)	f. - (please specify)
Pediatric inpatient	TMJ	
Peds Hematology/Oncology		
Primay Care		
Sedation		
Sedation Clinic		
Sedation Rotation		
Special Care Dentistry		
Special Needs		
Special Needs Patients		
REDACTED Clinic		
Teaching (Instruction)		
cleft lip/palate		
pediatric outpatient medicine		

28 (continued). Please indicate whether each Other hospital service rotation is required or an elective.

Question	Required	Elective	Total
d.	90.2%	9.8%	61
e.	90.0%	10.0%	40
f.	88.5%	11.5%	26

28 (continued). Please indicate the length of each Other hospital service rotation in weeks.

Field	Minimum	Maximum	Mean	Count
d.	0.2	50.0	6.2	61
e.	0.2	52.0	7.6	41
f.	0.5	48.0	5.7	26

28 (continued). Please indicate whether the number of hours per week spent by students/residents on each rotation.

Field	Minimum	Maximum	Mean	Count
d.	1.0	50.0	20.0	61

e.	1.0	40.0	18.1	41
f.	2.0	50.0	18.9	26

29. How many formal documented student/resident evaluations are conducted per year?

Field	Minimum	Maximum	Mean	Count
	2	200	6.0	84

Comments from Pediatric Dentistry Survey Curriculum Section page 3

D rotation is for second year residents only

#26 is the total number of patients seen by 6 residents for 2023-2024

- Emergency room is not a rotation, but part of the after-hours call component of the program. Residents on both sites (**REDACTED** and **REDACTED**) are on call 24 hours a day throughout the year.

2 summative assessments. We recently began formative assessments via Entrustable Professional Activities. Current survey doesn't allow to adequately reflect hours. Anesthesia rotation only occurs in the 1st year so it is skewing the hours. Pediatric medicine is 28 hours per week and on call is after hours 5 pm-6 am for 7 days at a time. Residents are on one week every 10 weeks.

28. Our residents take calls and provide emergency dental treatment per requests every day, including weekends and after hours for Emergency Depts at two **REDACTED** (at **REDACTED** and at **REDACTED**), but are not physically present in ED during working hours.

28.D. Our PGY2 residents rotate to **REDACTED** dental clinic approximately 1 day per month.

29. quarterly clinical progress evaluations by faculty; bi-annual formative evaluations by program director

3 formal evaluations in first year, 2 in second year (5 total per residency)

CPTI rotation will increase to 40 hours per week in the Fall of 2024. Additional rotations include: Trauma call (24 weeks/after hours emergency trauma call), Teaching at **REDACTED** Dental School (6 weeks/8 hours per week)

Each resident receives a formal clinical evaluation which is compiled from individual evaluations from all clinical faculty. Each resident receives a transcript report each semester from the **REDACTED** for all coursework completed during the semester.

For question 26 we had 11,100 patient visits in all of 2023-2024 academic year.

I had to fill some numbers because they survey will not let me move forward.

Once residents have completed their anesthesia rotation in their first year of training, they rotate through sedation/OMS in alternating months. Two days/week, they are trained in conscious sedation techniques and receive one month of OMS training to become competent in their extraction skill sets. Residents participate in 'Give Kids a Smile' and 'Jamaica Jams,' which are local advocacy community events

Our residents provide emergency care to pediatric patients at **REDACTED** Medical Center. It is part of their clinical duties and not a rotation.

PGY1 - 90 day; 6 mo; 12 mo / PGY2 - 18 mo; 24 mo

Patients managed include patients at **REDACTED** Clinic and off-site locations.

Pediatric Medicine Rotations include Hematology/Oncology, General Pediatrics, Cardiology, in addition to Emergency Medicine, Craniofacial, and Anesthesia.

Q29:Residents receive evaluations from faculty members in three clinical areas (clinic, operating room, on-call) at quarterly intervals, and receive two semi-annual reviews (mid-year, year-end).

Special Needs Clinic - residents attend clinic three times during their residency and 4 hours per session. Hematology Clinic - Residents attend clinic two times during their residency and 4 hours per session

The emergency department rotation is not required per the CODA guidelines, so we do not require a rotation. However, our dental residents are on call one out of every 5 nights for the emergency department and are called in frequently to treat emergency patients.

Two summative and two Entrustable professional activity-based evaluations per year.
We complete formal reviews biannually (Winter and Spring).
We conduct formal resident evaluations quarterly.
We participate in the Craniofacial Clinic 8 hours a month. Residents are assigned on a rotational basis.

CONSIDERATION OF REVISIONS TO ANESTHESIA STANDARDS OF THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PEDIATRIC DENTISTRY

Background: At its August 2021 meeting, the Commission on Dental Accreditation directed the establishment of a multidisciplinary Ad Hoc Committee composed of current and former Pediatric Dentistry Review Committee (PED RC) members as well as representation from the Dental Anesthesiology Review Committee and the Oral and Maxillofacial Surgery Review Committee to study the use of sedation in patient management, including the potential need for revision of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry, as applicable. The Ad Hoc Committee held meetings in November 2021 and submitted proposed revisions for consideration by the PED RC and Commission in Winter 2022.

At its Winter 2022 meeting, the PED RC recommended adoption of these revisions with immediate implementation, and the Commission concurred and directed that a definition of "Sole Primary Operator" be added to the Definition of Terms within the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry and an intent statement be added to Pediatric Dentistry Standard 4-7 to clarify that "Each patient encounter shall have only one (1) sole primary operator." The Commission also directed continued work by the Ad Hoc Committee to discuss outstanding issues related to its charge, with the inclusion of an additional member to provide further perspectives on the American Academy of Pediatric Dentistry anesthesia guidelines. As such, at its Winter 2022 meeting, the PED RC also recommended, and the Commission concurred, that the Commission invite the American Academy of Pediatric Dentistry's Chair of the Council on Clinical Affairs, Committee on Sedation and Anesthesia to join the Ad Hoc Committee as an additional member to provide a perspective on the potential revision to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry related to anesthesia education for pediatric dentistry, with a report to the Commission in Summer 2022.

At its Summer 2022 meeting, the PED RC carefully considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry submitted by the Ad Hoc Committee. Following discussion, the PED RC supported the proposed revisions to the standards submitted by the Ad Hoc Committee and recommended that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry be circulated to the communities of interest for review and comment, with Hearings held in conjunction with the October 2022 American Dental Association and March 2023 American Dental Education Association meetings, with comments reviewed at the Commission's Summer 2023 meetings. As directed by the Commission, the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry were circulated for comment through June 1, 2023.

Summer 2023 Review Committee and Commission Meetings: At its Summer 2023 meeting, the Pediatric Dentistry Review Committee considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry and the comments received prior to the June 1, 2023 deadline.

Through review of the written comments received, the PED RC noted comments from the state of California related to the state's requirement for minimal and moderate sedation permits. Other comments addressed the proposed revisions related to required patient encounters in which sedative agents are used and their relation to the current ADA Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students, particularly as they relate to providing sedation to patients eight (8) years of age or younger. The comments indicated that the requirements in the Standards are less stringent than the ADA Guidelines and that the Accreditation Standards should at least meet or exceed the ADA Guidelines to ensure pediatric dentistry program graduates have more advanced training requirements than that of dental students or general dentists.

Following lengthy discussion, the PED RC believed the proposed revisions required further consideration and should not be approved at that time. Further, the PED RC believed a workgroup of the members of the Review Committee, including the current and incoming Review Committee chair, should further consider the proposed revisions with a report to the Winter 2024 meetings of the PED RC and Commission. At its Summer 2023 meeting, the Commission concurred with the recommendation of the PED RC.

As directed, the Ad Hoc Committee conducted a virtual meeting on November 13, 2023 and discussed the Summer 2023 deliberations of the PED RC. Following discussion, the Ad Hoc Committee agreed further consideration of the revisions of Standard 4-7.b.1 related to providing sedation to patients 13 or under was warranted.

The Ad Hoc Committee discussed the proposed revision and believed identifying specific ages/age groups in the requirement is overly prescriptive. Further, the Ad Hoc Committee discussed that since pediatric dentistry patients could include individuals up to 18 years of age, programs should be encouraged to provide pediatric dentistry students/residents with educational experiences for patients between the ages of 13 and 18, not only those 13 or under as proposed in the initial Ad Hoc Committee's revision. Therefore, flexibility is warranted. In addition, the Ad Hoc Committee believed programs should be encouraged to provide training to ensure competency in providing sedation to younger patients, including both pre-school or school-age patients and determined a sentence clarifying this should be added to the intent statement. Following discussion, the Ad Hoc Committee determined the proposed revision to Standard 4-7.b.1 should be further modified and a correlating "intent" statement be modified.

Winter 2024 Review Committee and Commission Meetings: At its Winter 2024 meeting, the PED RC considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry, including the modified revisions recommended by the second Ad Hoc Committee. Following discussion, the PED RC agreed the modified revisions recommended by the second Ad Hoc Committee provided the flexibility warranted while still encouraging programs to provide training to competence in sedation to younger patients and believed all of the revisions should be adopted. The PED RC discussed whether the modified revisions warranted additional circulation to the communities of interest and determined additional circulation was not warranted because the modified revisions were not substantial in nature. The PED RC discussed an implementation period for the proposed revisions and believed an implementation date of January 1, 2025 would provide programs sufficient time to ensure compliance with all revisions. Therefore, the PED RC recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry and direct revision of all related documents for implementation on January 1, 2025.

At its Winter 2024 meeting, the Commission considered the recommendation of the PED RC. Through lengthy discussion, some members of the Commission expressed concerns about the modified revisions to Standard 4-7 b.2, specifically related to the lack of age requirements and a required number of sedations. In addition, some members of the Commission disagreed with the recommendation of the PED RC that the modified revisions not be circulated to the communities of interest for review and comment. Therefore, some members of the Commission believed the modified proposed revisions should not be adopted at that time and should be circulated to the communities of interest for review and comment.

Through further discussion, some members of the Commission noted the Standard, before proposed revisions, did not include an age range requirement and that the proposed revisions did not change the existing language in the "must" statement. Additionally, it was noted that the addition of the intent statement further strengthened the Standard. Therefore, some members of the Commission believed the proposed revisions, with the modifications, should be adopted without additional circulation and without further delay.

Following lengthy discussion, the Commission concurred with the recommendation of the PED RC and directed the proposed revisions be adopted and all related documents be revised, with an implementation date of January 1, 2025.

In a separate New Business discussion, at its Winter 2024 meeting, a motion was approved to reconsider the action of the Commission to adopt the proposed revisions to the pediatric dentistry Standards. Additional discussion followed surrounding the decision not to circulate the modified revisions because the PED RC believed the revisions were not significant and did not warrant recirculation. Again, some members of the Commission maintained that because the revisions

were substantial and due to the absence of numerical age requirements in the Standard, the modified proposed revisions should have been circulated to the communities of interest prior to the Commission's adoption. Through discussion, the Commission was again reminded that currently, the Standard has no age requirements. Some members of the Commission maintained that minimum requirements in terms of age categories of patients treated and experiences gained in advanced dental education programs are important and that when there are adverse outcomes of sedated children, it is often due to insufficient training and being unprepared to rescue a patient in trouble.

The Commission was also reminded that, generally, educational programs are competency-based and in previous years there were more quantitative requirements in the Standards. Nonetheless, each discipline typically determines the appropriate minimum number of procedures and other requirements within its Standards, with the expectation that each program in the discipline will ensure its graduates are competent.

Following lengthy discussion of the New Business item, the Commission maintained its previous recommendation to adopt the proposed revisions for implementation January 1, 2025. Additionally, the Commission directed the Review Committee on Pediatric Dentistry Education to reconsider patient age categories and the number of required experiences in patient age categories, related to the anesthesia requirements within the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry.

Summer 2024 Review Committee and Commission Meetings: As directed in Winter 2024, the PED RC met virtually on April 30, 2024. Following review of the Commission's charge, the PED RC further discussed the action of the Winter 2024 meeting. The PED RC discussed the various perspectives of the Commissioners that led to the decision to direct reconsideration of including patient age categories and required numbers of experiences in patient age categories, related to the anesthesia requirements, in the pediatric dentistry Standards. The PED RC also discussed its decision to not include age requirements in the "must" statement but to strengthen the Standard through the revised intent statement.

The PED RC discussed various ways that data regarding patient age categories and numbers of experiences could be gathered from pediatric dentistry education programs to obtain information on how the Standards are currently being achieved without revising Standards at this time. One option discussed was to review the Self-Study Guide used by programs, including Exhibits, to ensure alignment with the Standard and, as appropriate, consider modifying Exhibits to include specific sedation experiences. Another option discussed was to modify the pediatric dentistry Annual Survey to include information on the number of experiences by age group which could be used to determine whether there is an issue related to variability of patient experiences. The PED RC was reminded that the curriculum section is part of the upcoming 2024 Annual Survey, which will be distributed in August 2024, and the next curriculum section will occur in 2026.

Through further discussion, the PED RC concluded that, to provide baseline data, a question to the pediatric dentistry programs via the CODA Annual Survey would be helpful and believed the new survey question could be incorporated into the curriculum section of the Annual Survey. The PED RC concluded its discussion affirming that no changes should be made to the Standards until additional information is gathered through the Annual Survey to determine if revisions are warranted.

At its Summer 2024 meeting, the PED RC further reconsidered patient age categories and the number of required experiences in patient age categories, related to the anesthesia requirements within the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry. In doing so, the PED RC considered the Standards adopted at the Winter 2024 meeting and an unsolicited comment received related to Standard 4-7 b, as well as the recommendation of the PED RC following its April 30, 2024 meeting to add a new question to the Annual Survey with future consideration of data.

The PED RC carefully reviewed the proposed addition to the Annual Survey and noted that program directors may not understand what information/procedure numbers are being requested. Therefore, the PED RC further modified the proposed survey question by clarifying what experiences are being requested and for what age groups. Following lengthy discussion, the PED RC determined the proposed new survey question should be added to the curriculum section of the CODA Annual Survey for pediatric dentistry education programs. The PED RC was reminded that the curriculum section of the Annual Survey will be distributed in August 2024 and, after that distribution, the next curriculum section will be included in the 2026 Annual Survey.

The PED RC noted that following collection of data through the Annual Survey Curriculum Section, the Committee would have additional information to make an evidence-based decision on the need to further revise Standard 4-7 b to include age requirements, or to retain the Standard as written. The PED RC would consider the data of the new Annual Survey question during the Winter 2025 meeting, with an additional report to the Commission at that time. At its Summer 2024 meeting, the Commission concurred with the recommendation of the PED RC and directed the addition of a new survey question to be added to the Curriculum Section of the 2024 CODA Annual Survey.

As directed by the Commission, the new question within the Curriculum Section of the 2024 CODA Annual Survey was distributed to all pediatric dentistry programs in August 2024, with data analyzed in relation to a potential revision of Pediatric Dentistry Standard 4-7 b **(Appendix 1)**.

Summary: At the Winter 2025 meeting, the PED RC and Commission are requested to review the data collected in the 2024 Annual Survey specifically as it relates to Pediatric Dentistry Standard 4-7 b within the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry **(Appendix 1)**. The PED RC is requested to consider the need to further revise Standard 4-7 b, or to retain the Standard as written. The PED RC may recommend, and the Commission may direct, circulation of a proposed revision for a period of public comment or recommend no revision to the Standards at this time.

Recommendation:

Prepared by: Ms. Taylor Weast

AGGREGATE DATA OF THE 2024 ANNUAL SURVEY FOR PEDIATRIC DENTISTRY RELATED TO MINIMAL AND MODERATE SEDATION

24. What is the average number of experiences per student/resident using minimal and moderate sedation during the 2023-24 academic year?

a. Minimal sedation	Minimum	Maximum	Mean	Count
Less than 4 years old	0	500	17.4	84
4 years to less than 9 years old	0	772	71.8	84
9 years to less than 13 years old	0	510	40.0	84
13 years old and above	0	5,000	73.0	84

b. Moderate sedation	Minimum	Maximum	Mean	Count
Less than 4 years old	0	30	4.7	84
4 years to less than 9 years old	0	126	23.2	84
9 years to less than 13 years old	0	35	5.8	84
13 years old and above	0	30	2.5	84

CONSIDERATION OF ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PEDIATRIC DENTISTRY RELATED TO ADMINISTRATIVE OVERSIGHT AT MAJOR SITES WHERE EDUCATIONAL ACTIVITY OCCURS

Background: At its Winter 2024 meeting, the Commission considered the New Business report of the Review Committee on Predoctoral Dental Education (PREDOC RC), which included a discussion about the possibility of program directors working remotely and not in-person, on-site at one of the program's approved educational sites. The PREDOC RC recognized the Commission does not have a defined policy or requirement in some discipline-specific Accreditation Standards that stipulates the program director must be in-person, on-site to fulfill the duties as written in the Accreditation Standards. The PREDOC RC believed that CODA should clearly define this expectation for future interpretation of program director qualifications in accordance with the discipline-specific Accreditation Standards. Through a discussion, the PREDOC RC recognized that new technologies and an increasing remote workforce may allow program directors to complete some job tasks remotely. However, tasks such as supervision of faculty and some day-to-day job responsibilities would require the program director to be in-person, on-site at the program's approved educational sites. Additionally, for programs that have multiple approved educational sites that may be geographically separated from the sponsoring institution, including those throughout an individual state or located in different states, it is not clearly defined how much time the program director should spend at each site for supervision over the day-to-day operations, as listed in the discipline-specific Accreditation Standards, or the requirement to delegate site supervision responsibilities. The PREDOC RC believed CODA may need to investigate and review the in-person, on-site work expectations for program directors to determine if changes are needed to the Accreditation Standards for dental education, advanced dental education, and allied dental education programs. Following consideration, the Commission directed an Ad Hoc or Standing Committee to investigate in-person, on-site work expectations for program directors to determine if changes are needed in the discipline-specific Accreditation Standards for dental education, advanced dental education, and allied dental education programs.

Additionally, at its Winter 2024 meeting, the Commission considered the New Business report of the Review Committee on Dental Hygiene Education (DH RC) related to program administrators that may be remotely located from the program's campus. The DH RC considered whether there should be oversight of remote program sites by an on-site individual who reports to the program director. The DH RC noted that some advanced dental education Standards require an on-site supervisor at remote program locations. The Commission noted that the Dental Hygiene Review Committee would monitor trends in remote program locations for dental hygiene education.

Following consideration, at its Winter 2024 meeting, the Commission on Dental Accreditation (CODA) directed an Ad Hoc or Standing Committee to investigate in-person, on-site work expectations for program directors to determine if changes are needed in the discipline-specific Accreditation Standards for dental education, advanced dental education, and allied dental education programs.

Summer 2024: The Ad Hoc Committee, which was comprised of all current CODA Commissioners, met on August 7, 2024 at the ADA Headquarters, in association with the Commission's Summer 2024 meeting. The Ad Hoc Committee reviewed the background materials, which included the Commission's action leading to the Ad Hoc Committee, and the Standards for each discipline related to program director **(Appendix 1)**. The Ad Hoc Committee noted that the Advanced Education in General Dentistry, General Practice Residency Standards, and Pediatric Dentistry Standards include a requirement for a site director/site administrator at all off-campus clinical locations. The Committee discussed the changing environment in dental and dental hygiene education, noting increased establishment of off-campus sites where students spend a majority or all their time, much like a satellite campus. It was noted that while all CODA Standards have a requirement for clinical supervision at all educational activity sites, it was noted that most Standards do not address overall administrative oversight of the program, by the program director or a designee, at all sites where a student spends a majority or all their time. The Committee discussed whether virtual oversight or assignment of a responsible individual would be appropriate at all educational sites. The Committee believed there must be consistency in the educational program at all program sites.

Following consideration, the Ad Hoc Committee concluded that each Review Committee that does not currently have a Standard related to administrative oversight at major educational activity sites (e.g., off-campus sites where students spend a majority or all their time) should review this topic and determine whether a Standard is needed to address the Commission's expectation for administrative oversight, for consideration by the Commission in Winter 2025. In considering this matter, the Commission noted that inclusion of Intent Statements, in conjunction with proposed Standards, could further clarify the flexibility permitted for programs to oversee educational sites in a variety of ways, while ensuring administrative oversight and consistency in the educational program across all sites. At its Summer 2024 meeting, the Commission on Dental Accreditation concurred with the recommendations of the Ad Hoc Committee.

Summary: The Review Committee on Pediatric Dentistry Education is requested to review the Pediatric Dentistry Accreditation Standards **(Appendix 1)** related to administrative oversight at major educational activity sites (e.g., off-campus sites where students spend a majority or all their time) and determine whether a Standard is needed to address the Commission's expectation for administrative oversight. The Review Committee may determine that Standards already exist, which address overall administrative oversight of the program, by the program director or a designee, at all sites where a student/resident/fellow spends a majority or all their time. Alternately, the Review Committee may determine that Standards require modification or addition, and may propose changes to the Commission for further consideration including possible circulation to the communities of interest for a period of comment.

Recommendation:

Prepared by: Dr. Sherin Tooks

CONSIDERATION OF ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDCUATION PROGRAMS IN PEDIATRIC DENTISTRY RELATED TO DIVERSITY AND HUMANISTIC CULTURE AND LEARNING ENVIRONMENT

Background: At its Winter 2023 meeting, the Commission on Dental Accreditation (CODA) considered the Report of its Review Committee on Predoctoral Dental Education (PREDOC RC) related to the November 4, 2022 request from Dr. Lawrence F. Hill, president of The National Coalition of Dentists for Health Equity (NCDHE). The Commission directed the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs to consider the proposed revisions to Standards 1-3, 1-4 and 4-4 submitted by The National Coalition of Dentists for Health Equity (TNCDHE), with a future report to the Review Committee and Commission.

At its Summer 2023 meeting, the Standing Committee on Quality Assurance and Strategic Planning (QASP) discussed the February 16, 2023 letter and previously reviewed November 4, 2022 letter and materials from the NCDHE. The February 16, 2023 letter provided short term recommendations that would not require revision of the Accreditation Standards. The QASP members reviewed this topic again and believed that the TNCDHE letter appeared to focus on the enforcement of standards, calibration of site visitors, and diversity of CODA's site visitor volunteers. Following consideration of the QASP report, the Commission on Dental Accreditation directed a formal letter to The National Coalition of Dentists for Health Equity to inform the Coalition of the Commission's second review of its correspondence and actions that were underway by the Commission related to diversity, equity, inclusion and belonging.

On December 1, 2023, the Commission received a letter from TNCDHE **(Appendix 1)**. In its letter, TNCDHE provided short-term and long-term suggestions to CODA to improve diversity in all academic dental, allied dental, and advanced dental education programs.

The short-term suggestions from TNCDHE included:

1. Better training of site visit teams on how to assess whether an educational program has implemented a plan to achieve positive results.
2. Ensuring site visit teams are inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Further, when possible, site visit team members should be representative of dental schools with demonstrated success in increasing diversity and assuring a humanistic environment.
3. Redefining the meaning and intent of "diversity" in the Standards, considering the recent Supreme Court decision. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

The long-term suggestions from TNCDHE included:

1. Achieving a humanistic environment, addressing discrimination in policies and practice. Suggested revisions to the Accreditation Standards for Predoctoral Dental Education

Programs were provided.
2. Review of student admissions related to the underrepresented segments of the population enrolled in dental schools. Suggested revisions and additions to various Accreditation Standards were provided.
3. Considering Standards related to an inclusive environment in dental education. Suggested revisions and additions to various Accreditation Standards were provided.
4. Considering Standards related to access to care among diverse populations. Suggested revisions and additions to various Accreditation Standards were provided.

In Winter 2024, each Review Committee of the Commission provided comment to CODA on TNCDHE letter, which was reviewed by the Commission. Following consideration of Review Committee Reports, the Commission directed establishment of an Ad Hoc Committee composed of all Commissioners who chair the discipline-specific Review Committees in dental, allied dental, and advanced dental education, and additional CODA Commissioners, to study the Accreditation Standards for possible revision related to the letter from The National Coalition of Dentists for Health Equity.

Summer 2024: The Ad Hoc Committee, which was comprised of all current CODA Commissioners, met on August 7, 2024 at the ADA Headquarters, in association with the Commission's Summer 2024 meeting. The Ad Hoc Committee reviewed the background materials, which included the prior work of the Commission on this topic, the letters from TNCDHE, CODA Standards related to diversity and the humanistic culture including proposed revisions, Annual Survey data on dental programs related to diversity, and information from other accrediting agencies. The Committee engaged in extensive discussion related to TNCDHE's most recent letter of December 1, 2023, and the short-term and long-term recommendations of TNCDHE. The Commission noted the Predoctoral Dental Education Review Committee submitted a report to the Commission for consideration at the Summer 2024 meeting, including significant revisions to the Accreditation Standards addressing diversity and the humanistic culture among other proposed changes, which address some of the recommendations of TNCDHE. Additionally, it was noted that the Oral and Maxillofacial Surgery Review Committee submitted a report on proposed revisions related to diversity and the humanistic culture, following a period of public comment, which would also be reviewed at the Summer 2024 meeting. The Committee noted that this is an important topic, but other considerations must also be acknowledged including differences among institutions related to missions, resources, funding, state and federal regulations, and legal considerations. It was noted that some states do not permit initiatives focused on diversity, and the Commission cannot impose Standards that would conflict with state or federal law. As such, the Committee noted the proposed predoctoral dental education Standard revision, which discusses diversity efforts, would be consistent with university policy and state law. The Committee also noted that other dental organizations such as the American Dental Association (ADA) and American Dental Education Association (ADEA) are working to enhance diversity and these agencies should continue to support this effort.

Following consideration, the Ad Hoc Committee concluded that all Review Committees of the Commission should consider the proposed revisions for the Dental Standards 1-2 and 1-3 and

revisions for the Oral and Maxillofacial Surgery Standards 1-11 and 2-1.7 (adopted Summer 2024), for possible inclusion of similar Standards within the Review Committee's own discipline(s) to address diversity and the humanistic culture, with a report to the Commission in Winter 2025.

The Commission concurred with the Ad Hoc Committee's recommendation. Additionally, the Commission directed that work continue with further consideration of TNCDHE's December 1, 2023, short-term and long-term recommendations, with additional work to occur prior to the Commission's Winter 2025 meeting. The Commission also directed a letter, which was subsequently sent to The National Coalition of Dentists for Health Equity to provide an update on CODA's review of this matter, noting the topic's complexity and rapidly changing educational and regulatory environment, which must be monitored, while noting the Commission's commitment to a diverse academic environment.

Summary: The Review Committee on Pediatric Dentistry Education is requested to review the letter from The National Coalition of Dentists for Health Equity **(Appendix 1)**, as well as the Pediatric Dentistry Accreditation Standards, and reference materials including the proposed Dental Standards 1-2 and 1-3 and adopted revisions for Oral and Maxillofacial Surgery Standards 1-11 and 2-1.7 **(Appendix 2)**, for possible inclusion of similar Standards to address diversity and the humanistic culture. The Review Committee may determine that Standards already exist, which address diversity and the humanistic culture. Alternately, the Review Committee may determine that Standards require modification or addition and may propose changes to the Commission for further consideration including possible circulation to the communities of interest for a period of comment.

Recommendation:

Prepared by: Dr. Sherin Tooks

The National Coalition of DENTISTS for HEALTH EQUITY

December 1, 2023

Dr. Sherin Tooks, EdD, MS
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
tookss@ada.org

Dear Dr. Tooks,

Recommendations to increase diversity in dental education and practice via the Commission on Dental Accreditation Standards

The National Coalition of Dentists for Health Equity's mission is to support and promote evidence informed policy and practices that address inequities in oral health. One of our priorities is to advocate for greater diversity among dental students and faculty to better reflect the diversity of the US population in the oral health workforce.

In November of 2022, we wrote to the Commission on Dental Education (CODA), expressing concerns about the lack of diversity in predoctoral dental education and the apparent lack of enforcement of the CODA standards on diversity (hot link to our letter on our website). We observed that despite these standards, no dental schools (as of 2022) had received a recommendation related to diversity over the ten years that the standards had been in place. Our letter recommended new standards, policies, and procedures that would enhance diversity in predoctoral dental education. We were pleased to learn that CODA accepted our letter and referred it to a committee reviewing potential changes in the predoctoral standards and that the committee's report will be considered in the early 2024 CODA meetings.

Since 2022, we have spent additional time reviewing CODA standards for the other academic dental educational programs including dental hygiene, dental therapy and advanced education programs and realized our recommendations should also apply to these other programs. In this letter, we review our original recommendations, and propose additional ones for all educational programs.

We believe that the dental school accreditation standards utilized by CODA serve a vital role in achieving a diverse oral health workforce. However, we also believe that the current CODA predoctoral education standards do not appear to be encouraging academic dental institutions to recruit a more diverse student body or faculty. CODA adopted the new diversity predoctoral education standards 1-3 and 1-4 about ten years ago. However, recent data from the American Dental Education Association shows that "between 2011 and 2019, the percentage of HURE applicants increased only 2.2% annually on a compounded basis, Additionally, the proportion of all HURE dental school first-year, first-time enrollees for the entering class increased by only 3% between 2011 (13%) to 2019 (16%) (ADEA Report-Slow to Change: HURE Groups in Dental Education, https://www.adea.org/HURE/)" The conclusion we draw is that dental schools are not doing enough to recruit more HURE students to meet the intent of the CODA Standards.

We recognize that the recent Supreme Court decision to abolish the use of race in making admission decisions will prevent academic dental institutions from using race as a determining factor in admissions. The recommendations we make below do not suggest or presume that strategy.

In this letter, we are offering several additional suggestions to CODA to improve the diversity of all academic dental education programs, including predoctoral, dental hygiene, advanced educational programs and dental therapy. Three of these are short term recommendations that are not related to changing accreditation standards, with the understanding that CODA appropriately takes considerable time in changing standards which entails seeking input from many individuals, communities, and entities. In addition, we make another set of suggestions that are long term and include modifications to the “Examples of evidence to demonstrate compliance” for some of the standards. Our recommendations are based on papers found in recent Special Editions of The Journal of Public Health Dentistry and the Journal of Dental Education.

In particular, the longer-term suggestions build on the recommendations of the paper by Smith, PD, Evans CA, Fleming, E, Mays, KAI Rouse, LE and Sinkford, J, 'Establishing an antiracism framework for dental education through critical assessment of accreditation standards, as well as two additional papers in the Special Edition including Swann, BJ, Tawana D. Feimste, TD, Deirdre D. Young, DD and Steffany Chamut, S, 'Perspectives on justice, equity, diversity, and inclusion (JEDI): A call for oral health care policy;' and Formicola, AJ and Evans, C, 'Gies re-visited.' Note that some of these recommendations were included in the previous letter to CODA sent on November 4, 2022

SHORT-TERM SUGGESTIONS

Suggestion 1: We recommend that site visit teams be better trained on how to assess whether an educational program has implemented a viable plan that achieves positive results. Under the structural diversity section of the Standards, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is appropriate but showing an improvement in the diversity of the dental schools’ academic communities based on the school's plans and policies should also be demonstrated.

Since site visit teams are different for each school, there can be no consistency in the assessment process unless site visitors are given explicit expectations of what schools should demonstrate to comply with each of the two standards. CODA should develop a specific detailed orientation for each site visit team on what is acceptable and what is not acceptable for each of these two standards.

Suggestion 2: To be better able to assess whether schools meet diversity and humanistic standards, site visit teams should be inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Wherever possible, site visit team members should also be representative of dental schools that have demonstrated success in increasing diversity and assuring a humanistic environment.

Suggestion 3: Especially in light of the recent Supreme Court decision, CODA should redefine the meaning and intent of the term "diversity" in the Standards documents. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

LONG-TERM SUGGESTIONS

1) Achieving a humanistic environment- Not much is known about how dental schools address discrimination in their humanistic environment policies and practices. Although school policies on anti-discrimination might exist, students, faculty, and staff from underrepresented populations may still experience microaggressions, discrimination, racism, and barriers to socialization and mentorship. It has been suggested that such experiences may be underreported due to numerous factors, including fear of retaliation and/or disbelief that such concerns will be adequately addressed by the dental school. Because there are small numbers of underrepresented students, faculty, and staff in some dental schools, even anonymous humanistic surveys may not reveal these issues.

Suggested new "Examples of evidence to demonstrate compliance with Predoctoral Education Standard 1-3 may include:"

- Policies and procedures (and documentation of their effectiveness) implemented to seek feedback from traditionally underrepresented individuals concerning their experiences with the school's environment.
- Results of feedback that the school has sought from underrepresented students, faculty, and staff about their experiences with the school's environment.
- Documentation of the number and types of problems, complaints, and grievances reported about the school's environment, together with documentation of the school's effectiveness in addressing these issues.

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

2) Student Admissions

Despite the historical lack of students and faculty from underrepresented segments of the population enrolled in US dental schools, it appears that dental schools are rarely cited for not meeting Standard 1-4. One reason for this may be that the standard allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not appropriately emphasize certain specific underrepresented segments of the population and/or entirely represent the diversity of the local and regional population surrounding the schools, and/or reflect the national demographics in which the schools' graduates will practice their profession. Additionally, CODA provides no specificity for the level of engagement, with respect to recruitment, that dental schools should have with underrepresented populations

Suggested new "Examples of evidence to demonstrate compliance may include".

- Documentation that the school has implemented policies, procedures, and strategies to attract and retain students, faculty and staff from diverse backgrounds in order to achieve parity with the diversity profiles of the school's local, regional or national populations
- Documentation of longitudinal improvement in the diversity of the school's students, faculty, and staff. Where improvement is absent or minimal, documentation of the evaluation of strategies to improve diversity and of modifications made to these strategies to improve outcomes.

The intent of Standard 1-4 states that "admissions criteria and procedures should ensure the selection of a diverse student body with the potential of successfully completing the program". A problem is that the interpretation of this intent can vary dramatically from school to school. Admissions decisions are made by committees of people, and although there are trainings and processes to address implicit biases toward traditionally underrepresented applicants, the admissions process is still largely subjective. There are unique social and structural issues that exist for underrepresented applicants that must also be considered when assessing their potential for success. Those issues may influence undergraduate education academic achievements including GPA's and standardized tests. The question to admissions committees shouldn't necessarily be which applicant has the higher score, but rather does an applicant demonstrate appropriate academic achievements, despite a history of significant barriers, to successfully negotiate the curriculum.

Suggested new "Examples of evidence to demonstrate compliance may include:"

- Documentation of policies and procedures used to consider the unique social and structural constructs that affect traditionally underrepresented applicants in the admissions decision-making process.

- Documentation of procedures used to educate admissions committee members to implicit biases that may exist with respect to the potential of underrepresented applicants to excel in the academic program.
- Documentation of admissions criteria intended to assess not only academic achievements, but also the interest, desire, and commitment of applicants to learn about issues such as cultural competency, community-based practice, and addressing inequities in oral health within the population.

Standards 4-4 for Predoctoral Dental Education programs and Standard 4-2 for Dental Therapy programs state "Admission policies and procedures must be designed to include recruitment and admission of a diverse student population". There are no accreditation standards for Dental Hygiene or Advanced Educational programs that mandate that these programs have policies and practices to achieve a diverse student population. It is recommended that CODA add these standards with appropriate intent statements and examples of evidence to document compliance.

Generally, with respect to Standards 1-3, 1-4, and 4-4, we recommend that CODA strengthen the accountability that should undergird the standards. There must be accountability around these standards. Accountability must be built into the process of reviewing the standards, supporting site visitors in their work, and making sure that dental schools who fail to meet the standards are required to improve their practices and those dental schools who are exceeding the standards should be encouraged to continue to grow.

3) Inclusive Environments in Dental Education

Underrepresented students have a more difficult time achieving both success and a feeling of belonging in dental educational programs for a myriad of reasons.

To improve retention of students in dental education programs facing academic, social or emotional challenge, it is recommended that CODA strengthen the intent statement for student services (Standard 4-7 for predoctoral programs and Standard 4-12 for the dental therapy programs).

The intent statement should state "programs should have policies and procedures which promote early identification and subsequent mentoring/counseling of students having academic and/or personal issues which have the potential of affecting academic success or the personal well-being of students".

Dental Hygiene and Advanced Education programs have no accreditation standards that address academic or personal support for students having difficulties. It is recommended standards be added.

4) Access to Care among Diverse Populations

Access to dental care, and therefore oral and systemic health, is significantly compromised by a number of factors including race, gender, sexual orientation, economic status, education, and neighborhood environment, among other factors.

CODA should strengthen the intent statements with respect to graduates being competent in treating patients in all life stages (predoctoral standard 2-22, dental hygiene standard 2-12 and dental therapy standard 2-20) to assure that foundational knowledge is taught and clinical competence is assessed with respect to changes in oral physiology, the management of the various chronic diseases and associated therapeutics associated with aging, as well as psychological, nutritional and functional challenges manifested in many of these patients.

The intent statement of predoctoral standard 2-17, which addresses student's competence in managing a diverse population, is vague. It is recommended CODA strengthen predoctoral standard 2-17 by stating that "graduates MUST (currently reads should) learn about factors and practices associated with disparities in health status among vulnerable populations, including structural barriers, and must display competency in understanding how these barriers, including prejudices and policies regarding, but not limited to race, gender, sexual preferences, economic status, education and neighborhood environment, affect health and disease and access to care".

There are no standards for dental hygiene or advanced education programs that mandate that graduates be competent in treating a diverse population. CODA should add such standards to these programs.

According to the intent statement of predoctoral Standard 2-26, students working in community health care or service-learning settings are essential to the development of a culturally sensitive workforce. However, the standard merely states that the program makes available such learning environments and that students be urged to avail themselves of such opportunities. CODA should mandate the student’s participation in service-learning and/or community-based health centers clinics.

We are pleased to submit these suggestions to CODA and we hope they will be considered by CODA in our mutual efforts to increase the diversity of the dental workforce.

Sincerely,
Dr. Lawrence Hill DDS MPH
President, National Coalition of Dentists for Health Equity

cc:
American Dental Education Association - Dr. Karen West, President; Sonya Smith, Chief Diversity Officer, American Dental Education Officer

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

National Dental Association - Tammy Dillard-Steels, MPH, MBA, CAE, Executive Director; Dr. Marlon D. Henderson, President; Dr. Kim Perry, Chairman of the Board
Diverse Dental Society – Dr. Tamana Begay, President
American Dental Therapy Association – Cristina Bowerman MNM, CAE, Executive Director
Hispanic Dental Association - Dr. Christina Meiners, 2023 President; Juan Carlos Pierotti, Operations Manager
Society of American Indian Dentists - Dr. Cristin Haase, President; Janice Morrow, Executive Director;
American Dental Association – Dr. Ray Cohlmia, Executive Director; Dr. Jane Grover, Council on Advocacy for Access, and Prevention; Dr. Linda J. Edgar, President
American Dental Hygienists' Association – Jennifer Hill, Interim CEO; JoAnn Gurenlian, RDH, MS, PhD, AAFAAOM, FADHA Director, Education, Research & Advocacy
Community Catalyst – Tera Bianchi, Director of Partner Engagement; Parrish Ravelli, Associate Director, Dental Access Project
National Indian Health Board – Brett Webber, Environmental Health Programs Director; Dawn Landon, Public Health Policy and Programs Project Coordinator
American Institute of Dental Public Health – David Cappelli Co-Founder and Chair; Annaliese Cothron, Executive Director

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

COMMISSION ON DENTAL ACCREDITATION
STANDARDS RELATED TO DIVERSITY AND LEARNING ENVIRONMENT

Current Standards are in Black Font
New Adopted Standards are in Red Font
Proposed Standards are in Green Font

Discipline	Standard Number	Requirement of the Standard
Predoctoral Dental		
	Standard 1-3	The dental education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated. **Intent:** *The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.* **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 1-4	The dental school **must** have policies and practices to: a. achieve appropriate levels of diversity among its students, faculty and staff; b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity. **Intent:** *The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly*

		assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.
	Standard 2-17	Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment. **Intent:** *Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:* • *basic principles of culturally competent health care;* • *basic principles of health literacy and effective communication for all patient populations* • *recognition of health care disparities and the development of solutions;* • *the importance of meeting the health care needs of dentally underserved populations, and;* • *the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi- dimensionally diverse society.*
	Standard 2-26	Dental education programs **must** make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences. **Intent:** *Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.*
	Standard 4-4	Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population. **Intent 4-1 to 4-4:** *The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the selection of a diverse student body*

		with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non- discriminatory and ensure the quality of the program.
	Proposed Educational Environment	Among the factors that may influence predoctoral curricula are expectations of the parent institution, standing or emerging scientific evidence, new research foci, interfaces with specialty or other dental-related education programs, approaches to clinical education, and pedagogical philosophies and practices. In addition, the demographics of our society are changing, and the educational environment must reflect those changes. People are living longer with more complex health issues, and the dental profession will routinely be expected to provide care for these individuals. Each dental school must also have policies and practices to achieve an appropriate level of diversity among its students, faculty, and staff. While ~~diversity~~ variability of curricula is a strength of dental education, the core principles below promote an environment conducive to change, innovation, and continuous improvement in educational programs. Application of these principles throughout the dental education program is essential to achieving quality.
	Proposed ~~Humanistic~~ Learning Environment	Dental schools are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A ~~humanistic pedagogy~~ safe learning environment inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising, and small group interaction. A dental school environment characterized by: • physical and psychological safety, free of intimidation, abuse, and retaliation; • respectful and collegial professional relationships between and among faculty, staff, and students; and • ~~establishes~~ a context for the development of interpersonal skills necessary for learning, ~~for~~ and patient care~~, and for making meaningful contributions to the profession.~~
	Proposed Diversity and Inclusion	Diversity and inclusion in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, national origin, gender identity, age, physical abilities/qualities, sexual orientation, religions, and ideologic backgrounds; come from ~~cities~~ urban, rural areas, and from various geographic regions; and have a wide variety of interests,

		~~talents~~ abilities, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively homogeneous environment. Programs ~~must~~ strive to create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural, religious, and socioeconomic lines.
	Proposed Definition of Terms	**Cultural competence**: Having the ability to provide care to patients with diverse backgrounds, values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers' understanding the relationship between diversity of culture, values, beliefs, behavior, and language and the needs of patients. ~~**Dimensions of Diversity**: The dimensions of diversity include: structural, curriculum and institutional climate.~~ **Diversity - Structural:** Structural diversity, also referred to as compositional diversity, focuses on ~~the numerical distribution of~~ students, faculty, and staff from diverse backgrounds in a program or institution. ~~**Curriculum:** Curriculum diversity, also referred to as classroom diversity, covers both the diversity-related curricular content that promote shared learning and the integration of skills, insights, and experiences of diverse groups in all academic settings, including distance learning.~~ **Diversity - Institutional Climate:** Institutional climate, also referred to as interactional diversity, focuses on the general environment created in programs and institutions that support diversity as a core value and provide opportunities for informal learning among diverse peers.
	Proposed Standard 1-2	The dental education program **must** ~~have a stated~~ demonstrate a commitment to a ~~humanistic culture and~~ learning environment that includes: ~~is regularly evaluated.~~ a. a stated commitment and activities to promote a safe learning environment; b. regular evaluation of the learning environment, with input from faculty, staff, and students;

		c. actions aimed at enhancing the learning environment based on the results of regular evaluation. ~~**Intent:**~~ ~~*The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.*~~ **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Development of a Code of Conduct • Training to recognize and mitigate microaggressions, implicit and explicit bias, racism, gender identity and sexual orientation, hate speech, or other derogatory or harmful behaviors • Student, faculty, and ~~patient~~ staff groups involved in ~~promoting diversity,~~ professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, ~~patient, and alumni~~ and staff perceptions of the ~~cultural~~ learning environment
	Proposed Standard 1-3	The dental school **must** have policies and practices related to diversity and inclusion consistent with University policies and state law to: ~~a. achieve appropriate levels of diversity among its students, faculty and staff;~~ ~~b.~~ a. engage in ongoing systematic and focused efforts to attract and retain students, faculty, and staff from diverse backgrounds; ~~and~~ ~~c.~~ b. systematically evaluate ~~comprehensive~~ strategies to improve the ~~institutional climate for~~ dental school's diversity and inclusion.; and ~~d.~~ c. engage in actions aimed at enhancing the program's diversity and inclusion based on results of regular evaluation. **Intent:** ~~*The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate.*~~ *The dental school ~~should~~ articulate*s *its expectations regarding diversity, equity, inclusion, and belonging ~~across its academic community in the context of local and national responsibilities~~, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity and inclusion in their planning that include, but are not limited to,*

		gender, ethnicity, race, cultural, and socioeconomic factors. ~~*gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.*~~
	Proposed Standard 2-9	Instruction in social and behavioral sciences **must** be at an in-depth level and include: a. patient management, including cultural diversity and interpersonal communications skills; b. intra-professional collaboration, including communicating with other members of the oral health care team; c. inter-professional collaboration, including communicating with other members of the health care team; d. professional conduct, including ethical decision making; e. legal and regulatory concepts related to patient care; f. basic principles of practice management, including models of oral health care delivery, and how to function successfully as the leader of the oral health care team; and g. oral epidemiology, dental public health, and social determinants of health.
	Proposed Standard 2-10	Following patient experiences, graduates **must** demonstrate competence in social and behavioral sciences including: a. patient management, including cultural diversity and interpersonal communications skills; b. demonstration of intra-professional collaboration, including communicating with other members of the oral health care team; c. demonstration of inter-professional collaboration, including communicating with other members of the health care team d. adherence to professional conduct, including ethical decision making; and e. compliance with legal and regulatory concepts related to patient care.
	Proposed Standard 2-15	~~Dental education programs~~ The dental education program **must** make available community-based patient experience opportunities and encourage students to ~~engage in service learning experiences and/or community based learning experiences~~ interact with and treat patients in varied clinical environments. **Intent:** ~~*Service learning experiences and/or c*~~*Community-based learning experiences are* ~~*essential*~~ *valuable to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the* ~~*value of*~~ *community* ~~*service*~~*.*

	Proposed Standard 4-1	~~Specific w~~Written criteria, policies and procedures, including policies and procedures designed to recruit and admit a diverse student population, **must** be followed when admitting predoctoral students. **Intent 4-1 to ~~4-3~~ 4-4:** *The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures ~~should~~ ensure~~s~~ the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, ~~should~~ establish admissions procedures that are non- discriminatory and ensure the quality of the program.*
Dental Assisting		
	Standard 1-7	**There must be an active advisory committee to serve as a liaison between the program, local dental and allied dental professionals and the community. Dentists and dental assistants must be equally represented.** **Intent:** *The purpose of the advisory committee is to provide a mutual exchange of information for program enhancement, meeting program and community needs, standards of patient care, and scope of practice. Membership should include representation from a variety of practice settings. The program administrator, faculty, students, and appropriate institutional personnel are non-voting participants.* **Examples of evidence to demonstrate compliance may include:** •Membership responsibilities are defined and terms staggered to provide both new input and continuity •Diverse membership with consideration given to student representation, recent graduate(s), public representation, and a profile of the local dental community. •Responsibilities of program representatives on the committee are defined in writing. •Meeting minutes are maintained and distributed to committee members.
	Standard 2-14	**The dental science aspect of the curriculum must include content at the familiarity level in:** **a. Oral pathology** **b. General anatomy and physiology** **c. Microbiology** **d. Nutrition** **e. Pharmacology to include:** **i. Drug requirements, agencies, and regulations** **ii. Drug prescriptions**

		iii. Drug actions, side effects, indications and contraindications **iv. Common drugs used in dentistry** **v. Properties of anesthetics** **vi. Drugs and agents used to treat dental-related infection** **vii. Drug addiction including opioids and other substances** **f. Patients with special needs including patients whose medical, physical, psychological, or social conditions make it necessary to modify normal dental routines.**
	Standard 2-20	**The program must demonstrate effectiveness in creating an academic environment that supports ethical and professional responsibility to include:** **a. Psychology of patient management and interpersonal communication** **b. Legal and ethical aspects of dentistry** **Intent:** *Faculty, staff and students should know how to draw on a range of resources such as professional codes, regulatory law and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive or of public concern.* **Examples of evidence may include:** • Faculty, student, staff membership and participation in dental professional organizations, e.g., American Dental Assistants Association, American Dental Education Association, American Dental Association • Professional Code of Conduct • State Dental Practice Act • Student Handbook • Professional and ethical expectations
	Standard 2-21	**The dental assisting program must provide opportunities and encourage students to engage in service and/or community-based learning experiences.** **Intent:** *Community-based experiences are essential to develop dental assistants who are responsive to the needs of a culturally diverse population.* **Examples of evidence may include:** •Service hours •Volunteer activities
Dental Hygiene		
	Standard 1-2	**The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.** **Intent:** *The program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among*

		administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship. **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 2-12	Graduates must be competent in providing dental hygiene care for all patient populations including: 1) child 2) adolescent 3) adult 4) geriatric 5) special needs Intent: An appropriate patient pool should be available to provide a wide scope of patient experiences that include patients whose medical, physical, psychological, developmental, intellectual or social conditions may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Student experiences should be evaluated for competency and monitored to ensure equal opportunities for each enrolled student. Clinical instruction and experiences should include the dental hygiene process of care compatible with each of these patient populations.
	Standard 2-15	Graduates must be competent in interprofessional communication, collaboration and interaction with other members of the health care team to support comprehensive patient care. Intent: Students should understand the roles of members of the health-care team and have interprofessional educational experiences that involve working with other health-care professional students and practitioners. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental Hygienists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).
	Standard 2-19	Graduates must be competent in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management. Intent: Dental hygienists should understand and practice ethical behavior consistent with the professional code of ethics throughout their educational experiences.

Dental Laboratory Technology		
	Standard 1-7	**There must be an active liaison mechanism between the program and dental professionals in the community.** **Intent:** *The purpose of the active liaison mechanism is to provide a mutual exchange of information for improving the program and meeting employment needs of the community.* *Meetings, either in-person or virtual, should be held at least once per year.*
	Standard 2-1	**Admission of students must be based on specific written criteria, procedures and policies. Minimum admissions requirements must include high school diploma or its equivalent. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability, and employment opportunities for dental laboratory technicians.** **Intent:** *Because the curriculum is science and technology-oriented and enrollment is limited by facility capacity, special program admissions criteria and procedures may be necessary. The program administrator and faculty, in cooperation with appropriate institutional personnel establish admissions procedures which are non-discriminatory, contribute to the quality of the program, and allow selection of students with potential for successfully completing the program.*
	Standard 2-7	**The basic curriculum must include content in the subject areas: general studies; physical sciences; dental sciences; legal, ethical and historical aspects of dentistry and dental laboratory technology; infectious disease and hazard control management; and, basic laboratory techniques.** **Intent:** *To ensure that foundational knowledge is established early in the program and that subsequent information is provided which is comprehensive and prepares the student to achieve competence in all components of dental laboratory practice. Content identified in each subject need not constitute a separate course, but the subject areas are included within the curriculum.*
	Standard 2-11	**The curriculum must include content in the legal, ethical and historical aspects of dentistry and dental laboratory technology to include:**

		a) Organizations that advance certification and continuing education for dental technicians and certification of laboratories. **b) Work authorization/prescription of the dentist in accordance with the state dental practice act, consistent with current procedures in dental laboratory technology in the geographic area served by the program.** **c) Federal and state laws and regulations related to operating a dental laboratory and/or working as a dental laboratory technician.** **d) HIPAA laws related to health care professionals** **e) Ethics for health care professionals** **Intent:** *The dental laboratory technology curriculum prepares students to assume a professional and ethical standard to understand the basic foundation in which the fundamentals of dental laboratory technology were established.*
Dental Therapy		
	Standard 1-3	The dental therapy education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated. **Intent:** *The dental therapy education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.* **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 1-4	The program **must** have policies and practices to: a. achieve appropriate levels of diversity among its students, faculty and staff; b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

		Intent: *The program should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The program should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Programs could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Programs should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.*
	Standard 2-14	Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment. **Intent:** *Students should learn about factors and practices associated with disparities in health status among populations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental therapy practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental therapy education in:* • *basic principles of culturally competent health care;* • *basic principles of health literacy and effective communication for all patient populations;* • *recognition of health care disparities and the development of solutions;* • *the importance of meeting the health care needs of dentally underserved populations, and;* • *the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.* *Dental therapists should be able to effectively communicate with individuals, groups and other health care providers. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental therapists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).* **Examples of evidence to demonstrate compliance may include:** • student projects demonstrating the ability to communicate effectively with a variety of individuals and groups.

		• examples of individual and community-based oral health projects implemented by students during the previous academic year • evaluation mechanisms designed to monitor knowledge and performance
	Standard 2-24	Dental therapy education programs **must** have students engage in service learning experiences and/or community-based learning experiences. **Intent:** *Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.*
	Standard 4-2	Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population. **Intent:** *Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program*.
Advanced Education in General Dentistry		
	Goals 2, 6, 7	2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs. 6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 7. Understand the oral health needs of communities and engage in community service.
	Standard 1-10	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to*

		guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
	Standard 2-1	The program **must** provide didactic and clinical training to ensure upon completion of training, the resident is able to: a) Act as a primary oral health care provider to include: 1) providing emergency and multidisciplinary comprehensive oral health care; 2) obtaining informed consent; 3) functioning effectively within interdisciplinary health care teams, including consultation and referral; 4) providing patient-focused care that is coordinated by the general practitioner; and 5) directing health promotion and disease prevention activities. b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs. c) Manage the delivery of patient-focused oral health care. ***Intent:*** *"Patients with special needs" is defined in the Definition of Terms on page 10 of this document.* *Patient-focused care should include concepts related to the patient's social, cultural, behavioral, economic, medical and physical status.*
General Practice Residency		
	Goals 2, 7, 8	2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs. 7. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 8. Understand the oral health needs of communities and engage in community service
	Standard 1-10	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

		Intent: *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 2-1	The program **must** provide didactic and clinical training to ensure upon completion of training, the resident is able to: a) Act as a primary oral health care provider to include: 1) providing emergency and multidisciplinary comprehensive oral health care; 2) obtaining informed consent; 3) functioning effectively within interdisciplinary health care teams, including consultation and referral; 4) providing patient-focused care that is coordinated by the general practitioner; and 5) directing health promotion and disease prevention activities. b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs. c) Manage the delivery of patient-focused oral health care. ***Intent:*** *"Patients with special needs" is defined in the Definition of Terms on page 10 of this document.* *Patient-focused care should include concepts related to the patient's social, cultural, behavioral, economic, medical and physical status.*
Dental Anesthesiology		
	Standard 1-10	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*

	Goals 2, 7	2. Plan and provide anesthesia-related care for the full range of dental patients, including patients with special needs. 7. Utilize the values of professional ethics, lifelong learning, patient-centered care, adaptability, and acceptance of cultural diversity in professional practice.
	Standard 2-1	The program **must** list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.
	Standard 2-6	The following list represents the minimum clinical experiences that **must** be obtained by each resident in the program at the completion of training: a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: (1) Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty five (25) advanced airway technique requirements can be blind nasal intubations. (2) One hundred and twenty five (125) children age seven (7) and under, and (3) Seventy five (75) patients with special needs, and b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation.
Dental Public Health		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments,

		complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-2	Graduates **must** receive instruction in and be able to apply the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, practice management, and programs to promote the oral health of individuals and communities. ***Intent:*** *Graduates are expected to know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern. Graduates are expected to respect the culture, diversity, beliefs and values in the community.*
Endodontics		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of

		Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 1-1	Graduates **must** receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *Intent: Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
Oral and Maxillofacial Pathology		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-8.1	**Graduates must have an understanding of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.**

		Intent: *Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern*
Oral and Maxillofacial Radiology		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-3	Graduates **must** be able to apply the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
Oral and Maxillofacial Surgery (Residency)		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care

		without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-16	Graduates must receive instruction in the application of the principle of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *Intent: Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 1-11	The program and sponsoring institution's collaborative responsibilities must include an ongoing effort for recruitment and retention of a diverse and inclusive workforce of faculty, residents and staff. Examples of evidence to demonstrate compliance may include: • Nondiscriminatory policies and practices at all organizational levels. • Mission and policy statements which promote diversity and inclusion. • Evidence of training in diversity, inclusion, equity, and belonging.
	Standard 2-1.7	The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated. **Intent:** *The program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, residents, staff, and alumni. The program*

		should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, residents, and staff, open communication, leadership, and scholarship. Examples of evidence to demonstrate compliance may include: • Established policies regarding ethical behavior by faculty, staff and residents that are regularly reviewed and readily available • Resident, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on resident, faculty, patient, and alumni perceptions of the cultural environment
	Standard 2-1.8	The program director and teaching staff must lead by example in all aspects of professionalism. ***Intent:*** *The purpose of the program's culture and environment is to promote excellence in safe, high-quality care, preparing residents for lifetime learning and a successful future professional life. Practices and policies that exemplify faculty well-being and promote resident well-being in a humanistic environment, while not compromising on quality and safety, create the optimal culture and environment. Professionalism, integrity, and an open culture; where problems can be raised and solved as a team, allow for progress and flexibility while promoting a shared responsibility of all involved to create and maintain an optimal educational environment. Program directors' and teaching staff model, at all times, excellence in patient care, demonstrated by safe and compassionate clinical practice, integrity in their approach to service and scholarly activity, respect for others, especially residents, in their efforts to assure an optimal educational environment.* *Examples of evidence to demonstrate compliance may include:* • *Written evaluations from faculty and the chair of the program director and teaching staff.* • *Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.* • *External evaluations of culture, climate, and learning environment.* • *Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation*
	Standard 2-1.9	Lines of communication must be established and ongoing within the program to address culture concerns without the fear of retaliation.

		Examples of evidence to demonstrate compliance may include: • Written evaluations from faculty that occur at least twice a year. • Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard. • Anonymous evaluations of culture, climate, and learning environment. • Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation. • Policies and requirements that promote an optimal educational experience, working culture and environment.
	Standard 4-18.1	The program must provide resident supervision to promote safe and optimal patient care. ***Intent:*** *Comprehensive guidelines and consistent communication assist residents in decision making regarding the balance between a relatively autonomous learning environment and direct supervision of patient care. Patient care is a shared responsibility among faculty and residents with the faculty ultimately responsible. Supervision ensures safety and excellence. Supervision is accomplished through a variety of methods including direct supervision with physical presence and where applicable indirect supervision including the use of fellows or residents or through means of telecommunication and general oversight.* Examples of evidence to demonstrate compliance may include: • Resident supervision policy • Documented resident responsibility based on OMS benchmarks or similar metrics. • Faculty and resident call schedules • Documentation of didactic and clinical competency or Core Entrustable Professional Activities (EPAs) • Didactic sessions focused on the process of progressive entrustment.
	Standard 4-21 (4-21.1 – 4-21.4)	Residents must be educated in wellness, impairment, burnout, depression, suicide, and substance abuse as well as on the importance of adequate rest to avoid fatigue in order to balance their professional lives and deliver high quality care. ***Intent:*** *It is understood that many competing interests exist both within and outside of their commitment to residency obligations. Residents need to understand the value of wellness and fatigue and have the ability to openly address individual and programmatic concerns. Programs need to be responsive to concerns raised regarding out of balance or inappropriate burdens placed on residents that undermine the primary purposes of their training.*

		Programs also need to look for resident duties that could be reasonably offloaded to non-residents in order to optimize resident education, promote wellness, and avoid fatigue. Examples of evidence to demonstrate compliance may include: • ROAAOMS Wellness Webinar Series • Resident Evaluations of the program • SCORE and/or institutional modules on wellness 4.21.1 The program must have policies in place that promote faculty and residents looking out for the wellness of one another and fitness for patient care with mechanisms for reporting at-risk behaviors without the fear of retaliation. 4-21.2 Programs must blend supervised patient care, teaching responsibilities of residents, didactic commitments, and scholarly activity of residents such that it is accomplished without the excessive reliance on residents to fulfill other service needs and without compromising wellness and fatigue. 4-21.3 Resident work hours must be monitored and reviewed. *Intent:* It is required that programs have a system in place for ongoing monitoring of weekly work hours including total number of hours worked, time off between shifts, and days off per week. This data can then be reviewed in appropriate settings such as faculty and resident meetings, annual reviews, and morbidity and mortality conferences. The tracking of hours creates data for shared decision making and assists programs in addressing outlying individuals or situations that could be avoided with more effective training and programmatic structure. 4-21.4 The program must have policies and procedures which allow residents leaves of absence from work in order to address issues not limited to fatigue, illness, family emergencies, and parental leave.
Oral and Maxillofacial Surgery (Fellowship)		
	None	
Oral Medicine		
	Goals 6, 7	6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 7. Understand the oral health needs of communities and engage in community service.

	Standard 1-12	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 2-12	The educational program **must** provide training to the level of competency for the resident to: a) perform a comprehensive physical evaluation and medical risk assessment on patients who have medically complex conditions and make recommendations for dental treatment plans and modifications;
Orofacial Pain		
	Goals 2, 10	2. Plan and provide interdisciplinary/multidisciplinary health care for a wide variety of patients with orofacial pain. 10. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
	Standard 1-11	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 2-10	The program **must** provide training to ensure that upon completion of the program, the resident is able to manage patients with special needs. ***Intent****: The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident's ability to manage patients with special needs.*
Orthodontics and Dentofacial Orthopedics (Residency)		

	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 1-1	Graduates **must** receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *Intent: Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 4-3.2	**An advanced dental education program in orthodontics and dentofacial orthopedics requires extensive and comprehensive clinical experience, which must be representative of the character of orthodontic problems encountered in private practice.** ***Intent****: The intent is to ensure there is diversity in the patient population so that the students/residents will learn to treat a variety of orthodontic problems from the primary to adult dentition.*
Orthodontics and Dentofacial Orthopedics (Fellowship)		
	None	

Pediatric Dentistry		Note: The nature of the discipline requires treating infant, child, adolescent and patients with special healthcare needs.
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-6	Didactic Instruction: Didactic instruction in behavior guidance **must** be at the in-depth level and include: a. Physical, psychological and social development. This includes the basic principles and theories of child development and the age-appropriate behavior responses in the dental setting; b. Child behavior guidance in the dental setting and the objectives of various guidance methods; c. Principles of communication, listening techniques, and communication with parents and caregivers; d. Principles of informed consent relative to behavior guidance and treatment options; e. Principles and objectives of sedation and general anesthesia as behavior guidance techniques, including indications and contraindications for their use in accordance with the REFERENCE MANUAL; and f. Recognition, treatment and management of adverse events related to sedation and general anesthesia, including airway problems. ***Intent:*** *The term "treatment" refers to direct care provided by the residents/student for that condition or clinical problem. The term*

		"management" refers to provision of appropriate care and /or referral for a condition consistent with contemporary practice and in the best interest of the patient.
	4-7	Clinical Experiences: Clinical experiences in behavior guidance **must** enable students/residents to achieve competency in patient management using behavior guidance: a. Experiences **must** include infants, children and adolescents including individuals with special health care needs, using: 1. Non-pharmacological techniques; 2. Sedation; and 3. Inhalation analgesia. b. Students/Residents **must** perform adequate patient encounters to achieve competency: 1. Students/Residents **must** complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and 2. Students/Residents **must** complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used. The agents may be administered by any route.
	Standard 4-7	Clinical Experiences: Clinical experiences in behavior guidance **must** enable students/residents to achieve competency in patient management using behavior guidance: a. Experiences **must** include infants, children and adolescents including individuals with special health care needs, using: 1. Non-pharmacological techniques; 2. Minimal ~~S~~sedation; and 3. Moderate sedation ~~Inhalation analgesia~~. b. Students/Residents **must** perform adequate patient encounters to achieve competency: 1. ~~Students/Residents **must** complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and~~ 2. 1. Students/Residents **must** complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used to sedate pediatric patients or patients with special health care needs. The

		agents may be administered by any route.
	Standard 4-20	Didactic Instruction: Didactic instruction **must** be at the understanding level and include: a. The design, implementation and management of a contemporary practice of pediatric dentistry, emphasizing business skills for proper and efficient practice; b. Jurisprudence and risk management specific to the practice of Pediatric Dentistry; c. Use of technology in didactic, clinical and research endeavors, as well as in practice management and telehealth systems; d. Principles of biomedical ethical reasoning, ethical decision making and professionalism as they pertain to the academic environment, research, patient care and practice management; and e. Working cooperatively with consultants and clinicians in other dental specialties and health fields, including interprofessional education activities. Didactic instruction **must** be at the in-depth level for the following: f. The development and monitoring of systems for prevention and management of adverse events and medical emergencies in the dental setting; g. Exposure to the principles of quality management systems and the role of continuous process improvement in achieving overall quality in the dental practice setting; h. Exposure to the principles of ethics and professionalism in dental practice is an integral component of all aspects of this process improvement experience; and i. Employing principles of quality improvement, infection control, and safety, including an understanding of the mechanisms to ensure a safe practice environment. ***Intent:*** *(d) Graduates should draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern, (e) The student/resident learns to prevent, recognize and manage common medical emergencies for infants and children through adolescence and when to refer to other health care professionals and (g) Graduates should experience the elements of process improvement and the manner in which to involve the entire team*
	Standard 4-22	Didactic Instruction: Didactic instruction **must** be at the in-depth level and include: a. Formulation of treatment plans for individuals with special health care needs. b. Medical conditions and the alternatives in

		the delivery of dental care that those conditions might require. c. Management of the oral health of individuals with special health care needs, i.e.: 1. Medically compromised; 2. Physically compromised or disabled; and diagnosed to have developmental disabilities, psychiatric disorders or psychological disorders. 3. Transition to adult practices ***Intent:*** *(a) The student/resident learns how and when to modify dental care options as required by a patient's medical condition; and (c) Individuals with special health care needs include those with* *medical, physical, psychological or social circumstances that require modification in normal dental routines to provide dental treatment.*
	Standard 4-23	Clinical Experiences: Clinical experiences **must** enable students/residents to achieve competency in: a. Examination, treatment and management of infants, children, adolescents and individuals with special health care needs; and b. Participation in interprofessional experiences and collaborative care, including craniofacial teams. ***Intent:*** *Pediatric dentists often remain providers of oral health care for individuals with special health care needs into adulthood and should be able to render basic dental services to adults with special health care needs. These individuals include (but are not limited to) individuals with developmental disabilities, craniofacial anomalies, complex medical problems and significant physical limitations. Management should be understood to include consideration of social, educational, vocational and other aspects of special health care needs.*
	Standard 4-28	Didactic Instruction: Didactic instruction **must** be at the understanding level and include: a. The fundamental domains of child advocacy including knowledge about the disparities in the delivery of dental care, issues pertaining to access to dental care and possible solutions; b. The social determinants of health and the impact on general and oral health; c. Services available through healthcare and oral healthcare programs for at-risk populations, such as U.S. governmental programs (e.g., Medicaid and SCHIP); and

		d. Principles of learning and teaching to diverse audiences. ***Intent:*** *Pediatric dentists serve as the primary advocates for the oral health of children. The intent of the competency standards is to ensure that the resident is adequately trained to assume this role. Such training includes enhancing knowledge about oral health disparities and available services within the state and federal programs directed at meeting those needs. It also includes knowledge about their role as advisors to policy makers and organized dentistry.*
	Standard 4-29	Experiences: Experiences **must** provide exposure of the student/resident to: a. Communicating, teaching, and collaborating with groups and individuals on children's oral health issues; and/or b. Advocating and advising public health policy legislation and regulations to protect and promote the oral health of children; and/or c. Participating at the local, state and/or national level in organized dentistry and child advocacy groups/organizations to represent the oral health needs of children, particularly the underserved.
Periodontics		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

		The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 1-1	Graduates **must** receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *Intent: Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 2-1.a	The program director **must** have primary responsibility for the organization and execution of the educational and administrative components of the program. The director must devote sufficient time to the program to include the following: a. Utilize a faculty that can offer a diverse educational experience in biomedical, behavioral and clinical sciences;
Prosthodontics		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.

	Standard 4-21	Students/Residents **must** be competent regarding principles of ethical decision making pertaining to academic, research, patient care and practice environments. ***Intent****: Students/Residents should be able to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive or of public concern.*